Name: Anonymous

Submission date: 27/05/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an interested community member

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   Somewhat

2. What are the reasons for your answer?

   The quality and safety regulations are not cohesive or integrated across the health care sector. In many cases, they do not place the consumer and other key parties in the consumer's circle, i.e., other interested parties such as carers and family members, at the centre of the development of the regulations and standards. The role of the customer is central to all quality management frameworks. Instead, the standards and regulations are often written to reflect what the industry sector believes to be important- the fox is in charge of the hen house. This creates bias in the standards and regulations, which overlook the real needs of the users of these services and the place of these services in the community.

   For example, the pathology standards are written by ISO. The Committee responsible for writing the ISO standards is often comprised of accreditation bodies, with a vested interest in making the standards suit their customers, ie, pathology companies, rather than considering the needs of the patient and their carers and families. That leads to a lack of recognition that pathology results are often part of an integrated health service managed by a GP and there are no substantive requirements that reflect this integration. It is almost as if a pathology company is a stand-alone silo business, rather than a service that supports diagnosis of health status of a patient.

   By contrast, the ACSQHC's requirements described in the National Safety and Quality Health Service (NSQHS) Standards recognise the central nature of the patient in health service provision and have some provisions to address this aspect of service delivery. This kind of thinking has failed to make its way into ISO 15189 and any NATA/RCPA requirements. It leads to additional complexity for patients in accessing records and

quality health care services. A simple review of my own My Health records does not show ANY pathology results, even though I have a chronic health condition. I need to interact with my GP for those records, and if I were to go to a specialist or allied health provider, they do not have access to my health records to support treatment options.

The fundamental reasons for this silo mentality should be investigated and overcome for the benefit of the patient.

Further, decisions about accreditation criteria and duration of audits can have a profound effect on the viability of health care services. The failure to properly assess this aspect can lead to ever increasing loads of "small rules" without evaluating the effect of this kind of tinkering at the edges and its subsequent impact on efficiency. This was shown in a recent publication by Jones M et al. (2023) Australian Health Review doi:10.1071/AH23094

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   To a great extent

4. What are the reasons for your answer?

   The gaps between various requirements, particularly in terms of reporting, diagnosis and recognition by medical practitioners of the competence of other allied health care providers need to be addressed. Just because someone has a medical degree, or even a particular medical speciality, does not mean that they automatically know more about a patient or current technology. Development of quality and safety regulations and standards is not holistic and privileges certain voices, based on perceived qualification "superiority". For instance, a qualified pharmacist has a deeper understanding of matters such as pharmacology and interactions of medicines than a GP. Yet, there are no requirements for a GP to interact with pharmacists when prescribing treatments. This can be to the detriment of the patient.

   If the patient were placed in the centre of the regulations and standards, this would likely reveal the need for greater alignment across different care service sectors and jurisdictions, often without the inherent privileges placed on certain professionals over others. Patients can be "profession agnostic" and can assist with revealing efficiencies.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   The participant did not respond to this question.

2. What are the benefits of pursuing greater collaborative commissioning?

   The participant did not respond to this question.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

   The participant did not respond to this question.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

   The participant did not respond to this question.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

   The participant did not respond to this question.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

   The participant did not respond to this question.